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ON BEHALF OF

THE NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

REGARDING

MEDICAID: EMPOWERING BENEFICIARIES ON THE ROAD TO REFORM

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Introduction

Good morning, Chairman Barton and members of the committee. My name is Robert Sheehan, and I am the Chief Executive Officer of the Community Mental Health Authority of Clinton-Eaton-Ingham Counties. Each year, the CMH Authority provides a comprehensive range of services to adults and children with mental illnesses and substance abuse problems throughout a three-county area in Michigan. Central to our mission in providing services is the community mental health precept that anyone experiencing mental illness should have access to all the services they need, right in their own community, regardless of their ability to pay.

The National Council for Community Behavioral Healthcare is the national voice of organizations that share this philosophy. National Council members provide safety net mental health and substance abuse services to 5.9 million people in 1,200 communities across the United States. My comments today reflect the concerns of the National Council and the providers it represents.

On behalf of the CMH Authority of Clinton-Eaton-Ingham and the National Council, I applaud your efforts to examine how the Medicaid program can be modified to empower beneficiaries to fully participate in the process of attaining health and wellness.

Threats to Essential Medicaid Coverage

However, as you consider today the ways in which the Medicaid program can be improved, I also urge you to take a considered approach to Medicaid reform. It is important that first we do no harm as we change this program.

Unfortunately, I must report that a number of reform proposals that have arisen recently would bring disastrous consequences to people with mental illnesses and others who depend on the Medicaid program. Most of these proposals have been issued by national organizations as Congress has engaged in a fast track process of defining Medicaid cuts for budget reconciliation legislation.

Specifically, these harmful proposals include increasing co-payment and cost-sharing requirements for beneficiaries, reducing access to medications, and sharp restrictions on services such as rehabilitation and targeted case management that are crucial in meeting the healthcare needs of vulnerable populations such as people with severe mental illness.

Much of the negative impact of these proposals would fall on vulnerable populations for whom Medicaid plays a special role. As you are aware, Medicaid plays a particularly important role in providing mental health care, an area much of my testimony will focus on. According to the Substance Abuse and Mental Health Services Administration, Medicaid is the top payer for mental health services in the United States, and it also provides more than half of the funding for public mental health services.

Increasing Beneficiary Cost-Sharing and Co-Pays

As you consider ways of reforming Medicaid to reduce program costs, it is important to consider the impact of these changes on the health of beneficiaries as well as additional costs the program may bear if beneficiaries are unable to access the services and medications they need.

Studies of one of the most prominent Medicaid reform initiatives, the Oregon Health Plan Standard (OHP), have unfortunately found that beneficiary cost sharing has resulted in reduced access to services. One study, published last month in *Health Affairs*, found that 44 percent of Oregon Health Plan enrollees lost Medicaid coverage within six months after premiums and co-payments were increased. Earlier research, conducted by the Kaiser Commission on Medicaid and the Uninsured, found that beneficiaries reported a number of unmet health needs. For example, "nearly half reported not filling prescriptions due to cost, and over a third reported unmet mental healthcare needs."

Many of the healthcare access difficulties that arise from increased premiums and co-pays can be understood by examining the difficulties Medicaid beneficiaries face in making decisions about how they spend their limited incomes.

For example, consider the situation of people with psychiatric disabilities that depend on Medicaid. Many of these people are unable to work, and depend on SSI for their income. Nationally, monthly SSI cash benefits in most states averages less than $600. For individuals

with severe mental illnesses residing in supportive housing, board and care homes or other congregate living arrangements, most of their cash benefits are spent on their housing expenditures, and their disposable income consists of a minimal personal allowance that can be as low as $20 per week. Considering that people with severe mental illness often depend on 10 or more psychotropic medications, even a co-pay as low as $3 would become a substantial impediment to medications that are crucial to their health.

I can speak from personal experience about the tragic results of disrupting access to mental health care. On many occasions, when mental health consumers treated by the CMH Authority of Clinton-Eaton-Ingham have lost access to regular psychiatric treatment or medications, they have lost their jobs, housing, and sometimes their lives. In addition, this loss of regular care drives up overall costs in the healthcare system, as these consumer use more emergency and hospital-based services.

Many of these proposals to increase beneficiary cost-sharing will significantly reduce access to care, resulting in poor health outcomes and driving up healthcare costs.

Reducing Access to Medications for Vulnerable Populations

Other proposals that would limit access in order to achieve savings are also likely to have the unintended consequences of creating negative health outcomes and increasing costs. Again, I will focus on how these consequences are likely to be seen in the delivery of mental health services to people with severe mental illnesses.

Serious brain disorders are complex and costly conditions affecting a substantial portion of Medicaid beneficiaries. For any individual suffering from a serious mental illness, access to the right treatment in a timely manner is the key to clinical stability and the reduced overall cost of their health care. There are significant risks, both physically and financially, when care is limited or significantly delayed through mechanisms such as prior authorization, step therapy, and generic substitution.

There are numerous reasons why it is inadvisable to limit access to medications for patients with mental illness. For example, most psychotropic medications are not clinically interchangeable, even if they are classified in the same therapeutic category. These medications each work differently in each patient based on a multitude of factors, including age, sex and race. Only the patient's physician, in close interaction with the patient, is qualified to determine which medications are appropriate and tolerable for a patient's mental health treatment.

We have seen in our work in Michigan that patients who are not provided appropriate access to medications or who are treated with the wrong therapeutic agent end up using more costly health care intervention treatments including inpatient hospitalization, emergency room visits and intensive case management services. These patients will also be less adherent to prescribed medications in the future which again exacerbates the situation personally and financially.

Threats to Case Management and Rehabilitation Services in Mental Health

I turn now to a proposal that would affect two Medicaid services that play important roles in mental health. On August 5th, the Secretary of the Department of Health and Human Services sent model legislation to the Speaker of the House that would severely restrict Medicaid funding for case management and rehabilitation services. This proposal reflects a policy trend at the Centers for Medicare and Medicaid Services, a trend of increasing restrictions for these types of services. Unfortunately, this full implementation of this policy would decimate the US public mental health system.

Ironically, these threatened services – case management and rehabilitation – lie at the center of our nation's community-based approach to treating mental illnesses. It is these very services that are focused on engaging Medicaid beneficiaries in self-care activities that effectively improve clinical outcomes and reduce the use of costly hospital-based care.

This proposal to sharply restrict Medicaid funding for case management and rehabilitation services is surprising in light of HHS's leadership in promoting community-based, empowering health services for people with disabilities. This leadership was prominently displayed in the President's New Freedom Commission on Mental Health, which focused the nation's attention on promising approaches to address the nation's unmet mental health needs.

In its final report, the President's Commission established recovery from the disabling aspects of mental illness as the goal of the U.S. mental health system, and it specifically calls for the

expanded use of case management and rehabilitation services under Medicaid to enable more Americans with serious mental illnesses to reach this goal.

The Commission's call to expand the use of these programs in mental health reflects the healthcare industry's growing recognition of the importance of consumer empowerment in improving outcomes and saving money. Recognition of the value of teaching consumers how to manage their illnesses is reflected in the industry's widespread use of disease management programs, and the recent enactment of the Patient Navigator Act underscores the importance of providing consumers help in navigating the healthcare system.

I'd like to focus now on how case management and rehabilitation services empower mental health consumers.

Looking first at case management, at the Community Mental Health Authority of Clinton-Eaton-Ingham Counties, we provide one of the most prevalent models of this program, a type of case management called Assertive Community Treatment or ACT. While the effectiveness of ACT in improving clinical outcomes and quality of life is well supported by rigorous medical studies, I can speak most directly about the difference it makes in the lives of people with severe mental illness who live in the communities of central Michigan.

We provides ACT case management services to over 1,800 people with serious illnesses such as schizophrenia and bipolar disorder. Like all forms of case management, our ACT teams teach illness management skills and link people with psychiatric disabilities to a full range of needed

healthcare, rehabilitative, and social services. Furthermore, these teams teach consumers about their illnesses and how to best use medications and a range of supports to regain an optimal level of functioning. Should CMS's proposed restrictions apply to the CMH Authority of Clinton-Eaton-Ingham today, we anticipate that we would lose funding for this program altogether.

Looking briefly at rehabilitation services, there is consensus throughout the mental health field that these services are important in achieving good clinical outcomes and restoring functioning. The Substance Abuse and Mental Health Services Administration is actively promoting these services as part of its evidence-based practices program – reflecting the strong evidence base for these programs in the literature.

Given the recognized value of these programs, it is simply ironic that HHS's proposal would result in a catastrophic loss of funding for these programs.

The Alternative: Expanding Services that Empower Mental Health Consumers

In closing, I urge you to preserve and support services such as case management and rehabilitation that focus squarely on developing the skills of mental health consumers so they can participate in their treatment, experience recovery from psychiatric disability, and live full lives in their communities.

In addition to expanding access to these programs, Congress should look to the increased use of other services that empower consumers to pursue wellness. We have only begun to use disease

management programs in mental health – but the data arising from states such as Missouri show that patient care can be improved while reducing healthcare costs. Mr. Chairman and distinguished committee members, it is this kind of systemic change that should be the focus of your Medicaid reform efforts.